

PLEASE HAVE YOUR DOCTOR COMPLETE AND SIGN THIS FORM.
POR FAVOR ENTREGUE ESTA FORMA A LA OFICINA DE SU DOCTOR PARA QUE LA LLENE Y LA REVISEN. ENTREGUE ESTA FORMA CON SU APLICACIÓN LO MAS PRONTO POSIBLE. GRACIAS.



SUN METRO LIFT
5081 Fred Wilson
El Paso, Texas 79906

Dear Doctor,

The attached authorization form has been submitted by your patient, who has indicated that you can provide information regarding their disability and its impact upon their ability to utilize our wheelchair-lift-equipped regular city buses. Federal law requires that Sun Metro provide paratransit services only to persons who cannot utilize available accessible regular city buses. The information you provide will allow us to make an appropriate evaluation of this request and its application for specific trip requests. Thank you for your cooperation concerning this matter.

Capacity in which you know the applicant: _____

Medical Diagnosis of condition causing the disability: _____

Is the condition temporary? No ____ Yes ____

Expected duration until _____

If the person has a disability affecting mobility, is the person:

Able to travel $\frac{1}{4}$ mile without assistance? No ____ Yes ____

Sometimes _____

Able to wait outside for 10 minutes? No ____ Yes ____

Sometimes _____

Does the person use any mobility aids? If so, what? _____

If the person has a visual impairment, visual acuity with best correction:

Right eye ____ Left eye ____ Both eyes ____

Visual Fields:

Right eye ____ Left eye ____ Both eyes ____

If the person has a cognitive disability, is the person able to:

Give addresses and telephone numbers upon request?

No ____ Yes ____

Deal with unexpected situations or unexpected changes in routine?

No ____ Yes ____

Ask for, understand and follow directions?

No ____ Yes ____

Safely and effectively travel through crowded and/or complex facilities?

No ____ Yes ____

Be trained to transfer from one route to another on the regular city bus?

No ____ Yes ____

Is there any other condition of the disability of which Sun Metro should be aware? _____

Please describe disability and define effects in non-medical terminology: _____

Your Name: _____

Office Address: _____

Office Phone Number: _____

Signature: _____ Date: _____